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ABSTRACT

Clinical supervision is an inclass approach to instructional supervision that has as its goals improvement of instruction and teacher development. This paper includes the historical background of the develcpment of clinical supervision, an exposition of the content, an examination of related research, an analysis of its strengths and weaknesses, and a discussion of implications for the future. (Author/MLF)

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CLINICAL SUPERVISION

A STATE OF THE ART REVIEW

Cheryl Granade Sullivan

Association for Supervision and Curriculum Development

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Foreword

Clinical supervision would seem to have great potential for improvement of education. Its focus is the classroom, it deals directly with the processes of teaching and learning, and its tenets are in accord with principles of enlightened human behavior.

The potential is there, but it would not be accurate to say that clinical supervision has as yet made much of a contribution, or that it necessarily will. For the truth is that the thoroughly professional process described in the literature is found infrequently in practice.

The potential of clinical supervision and some of the reasons for its neglect are explored in this brief, readable review by Cheryl Sullivan. Coming at a time of intense interest in the evaluation and enhancement of teaching, this booklet makes an important contribution by sketching the origins of clinical supervision and summarizing research findings about its use.

Although elements of the process may be so familiar as to seem almost self-evident, we should recognize that the concept of, and rationale for, clinical supervision were developed quite recently. Of the 90 items in Cheryl Sullivan's bibliography, all but a very few were written in the 1970's. It's a young idea, and a productive one. With the help of books like this, we may be able to realize its potential.

BENJAMIN P. EBERSOLE
ASCD President, 1979-80

Introduction

The demands for leadership and responsibility in education today come from all segments of society. Sergiovanni and Starratt (1979) indicate that "people in the schools and on school committees are ready for some quiet and effective improvements" (p. 328). Teachers, students, and administrators alike are being held "accountable." Further, the personal demands on teachers appear to be great ("Truths About Teaching," 1979).

Clinical supervision is a specific supervisory approach which may respond to these educational needs. It has been characterized as "a structure by which instructional adequacy can be established" (Krey, Netzer, and Eye, 1977, p. 21).

If clinical supervision is capable of serving as a method (or, as some suggest, the panacea) of educational improvement, then a summary of its characteristics and associated field work needs to exist. If clinical supervision is nothing more than hollow claims, then the fallacies of the system need to be exposed. This paper includes historical background and the development of clinical supervision, exposition of the content of clinical supervision, examination of related research, analysis, and implications for the future as it reviews the state of the art. The purpose is to scrutinize carefully what does and what might exist as well as to pose questions for future investigations.

Clinical Supervision in History and the History of Clinical Supervision

Though supervisor preparation and supervisory practices have not been given major emphasis in education (Goldhammer, 1969), patterns of supervision have developed concurrently with the establishment and growth of schools in this country. Although educational historians differ on exact dates of various periods, there is considerable agreement in the literature about the progression of major emphases in supervision. It is this sequence which is helpful in providing the appropriate background for presenting the development and model of clinical supervision. Interestingly, it was the procedures that changed: the goal of inspecting teachers remained remarkably constant.

Trends in Instructional Supervision

1642–Late 1800's

Just as there was early concern by American settlers for the establishment of schools and for the content of curriculum, so was there need for supervision. For the most part, response to this need manifested itself in the selection of teachers or in the moral obligation to "keep school" (Alfonso, Firth, and Neville, 1975). Indeed, supervision in American schools from 1642 (the time of the Massachusetts Bay Law) until the late 19th century can be characterized as *school* (as opposed to *instructional*) supervision (Burnham, 1976). During this time, local or religious officers or special lay committees had supervisory control. Dickey (cited in Burnham, 1976) describes the three approaches to supervision which dominated the period: "(a) authority and autocratic rule; (b) emphasis upon the inspection and weeding out of weak teachers; and (c) conformity to stand-

ards prescribed by the committee of laymen" (p. 302). Clearly, the major supervisory task was inspection.

Late 1800's–1930's

During the period between the late 1800's and the 1930's, supervisory emphasis shifted from "keeping school" to focus on the instructional program as professional educators rather than lay committees assumed the supervisory role and accompanying duties. By the turn of the century, the principalship became a full-time position, and the principal gained recognition as the leader and manager of the school. Generally, however, the duties of the principal were in reality administrative, managerial tasks which included directing and monitoring teachers in ways not unlike the inspectional procedures of the earlier period.

A major change in educational emphasis occurred because of what Lucio (1962) characterizes as the "scientific movement." Efficiency became very important; and measurement, testing, and the setting of standards to be achieved by teachers and students became prominent tasks. Included in this move toward efficiency was the attempt to control teacher behavior and student performance. The study of educational problems employed scientific methodology. The National Education Association established a number of committees to examine the controversies and concerns stemming from the progressive movement and the need for education to respond to industrial, social, and political problems. Many of these groups (for example, *The Committee of Ten on Secondary School Studies* [1891], *The Committee of Fifteen on Elementary Education* [1895], *The Committee on the Economy of Time* [1911]) stressed in their work a scientific approach to decision making. Alfonso, Firth, and Neville (1975) summarize clearly the link between this general activity in education and supervisory practices: "The emphasis on organizational regimentation early in this century was to reflect efficient planning and the application of scientific methods. It served to further entrench the *inspectional* concept of supervision" (p. 21).

1930's–1950's

In the 1930's and 1940's, the educational orientation shifted to a concern for human relations and cooperative group effort to

improve instruction which prevailed through the late 1950's. Lucio (1962) describes the result in supervision:

> While the use of human relations techniques in working with groups and individuals did take into account the feelings and motives of teachers and supervisors and was probably appropriate to some areas of action, not enough attention was given to individuals' properties as reasoning human beings and the application of rational thought to problems requiring intellectual attack (p. 213).

As opposed to the overtly inspectional functions performed earlier, "the concept of supervision as democratic, cooperative, and creative guided the practice" (Burnham, 1976, p. 303).

Democratic supervision was concerned with the teacher achieving maximum professional efficiency. Increasing emphasis was placed on exchange of ideas and human interaction. Gwynn (1961) indicates three major areas of emphasis: supervision as guidance, supervision as curriculum development, and supervision as group processes. "Supervision as human relations" was advocated in the writings and leadership efforts of Kimball Wiles. While these efforts were often basically grounded in the knowledge of psychology (especially Gestalt) and group processes, and, as Gwynn (1961) states, the supervisor was no longer an inspector, Lucio (1962) indicates that "manipulative techniques were more often emphasized than theoretical constructs in working with groups and individuals" (p. 213).

1960's

General interest in technological advancement and scientific research combined with the availability of federal funds to make the 1960's a period in which activity in supervision was primarily oriented toward conducting or applying findings of research. The accountability movement gave further impetus to a drive toward specifying goals and measuring results. It was especially during this period that research and theory from the behavioral sciences was used "to search more diligently for a conceptual framework for the basis of supervisory practices" (Burnham, 1976, p. 303).

While the search for the conceptual base was in progress, the daily tasks of supervisors diversified. As early as the 1950's (Alfonso, Firth, and Neville, 1975) and into the 1960's, at least some supervisors functioned as agents of change. Neville (1966) asserted

that supervisory duties included identifying instructional problems, being a resource person, and serving as an expert in group dynamics in addition to the change agent role. Those responsible for supervisory duties continued to be principals, general and specialized supervisors, and curriculum directors.

This very general outline of the history of supervision gives credibility to Ryan's (1971) assessment of supervisory practice prior to the time of Goldhammer's (1969) book, *Clinical Supervision:*

> Traditionally supervision was carried out by a principal or some authority figure in the school system. Its purposes were to monitor the performance of teachers, occasionally to give new ideas, but generally to keep teachers on their toes (p. 556).

Development of Clinical Supervision

Clinical supervision was developed by Morris L. Cogan and others at Harvard during the 1950's. It was, in contrast to other supervisory efforts, designed as a professional response to a specific problem. Though the supervision given to student teachers in Harvard's MAT program was fairly standard and has been characterized as "at least as good as student teachers—*any* teachers—generally receive" (Wilhelms, in Foreword to Cogan, 1973, p. ix), Cogan and his colleagues decided that their supervisory practices of observing a lesson and then conferring with the teacher were inadequate. They proceeded to develop a model which was subsequently reviewed and revised. Initially, clinical supervision was used in the Harvard preservice program, but it quickly became part of inservice education. It was used with experienced teachers in the Harvard-Lexington and Harvard-Boston programs.

Interestingly, clinical supervision has components that reflect the major trends of the time during which it was developed and implemented. Its design shows evidence of the cooperative effort that characterized the 1950's. Clinical supervision requires that teacher and supervisor attack problems together and "rests on the conviction that instruction can only be improved by direct feedback to a teacher on aspects of his or her teaching that are of concern to that teacher (rather than items on an evaluation form or items that are pet concerns of the supervisor only)" (Reavis, 1976, p. 360).

It fits well Burton and Brueckner's (1955) definition of "modern supervision" in that "it involves the systematic study and analysis of the entire teaching-learning situation utilizing a carefully planned program that has been cooperatively derived from the situation and which is adapted to the needs of those involved in it" (p. 13). Yet, it goes beyond these definitions as it deals with the "conceptual framework" sought in the 1960's and clarification of the tasks of the supervisor.

The significant way in which clinical supervision differs from the previous supervisory approaches is in its content. It is historically and substantially unusual because of its emphasis on analysis rather than inspection and its presentation of a model rather than the smorgasbord of lists, charts, tables, and examples which so often occur in supervision literature (for example, *Supervisory Behavior in Education*, Harris, 1975; *Emerging Patterns of Supervision: Human Perspectives*, Sergiovanni and Starratt, 1971; and *Instructional Supervision: A Behavior System*, Alfonso, Firth, and Neville, 1975).

The Design of Clinical Supervision

Clinical supervision is a field-based approach to instructional supervision. The word *clinical* was chosen as a label to "denote and connote the salient operational and empirical aspects of supervision *in the classroom*" (emphasis added) (Cogan, 1973, p. 9). Goldhammer (1969) stresses that it describes "supervision up close" (p. 54). Clinical supervision has nothing to do with illness or pathological or psychological disorders but rather focuses on professional practice in field settings in education.

In order to facilitate analysis and evaluation at a subsequent time, the design of clinical supervision is presented in this section. Underlying propositions and values will be described as well as the clinical supervision model. In order to place these ideas in the proper perspective, emphasis must be placed on the fact that the propositions and values come from experience rather than a documented, empirical base (McCleary, 1976).

Propositions

There are several propositions upon which clinical supervision is based. The first is that teaching is behavior. This means that teaching includes the teacher's actions and the actions of pupils. The actions are observable singly and in interaction. It is important to emphasize that Cogan includes both performance and results as part of teaching (Mosher and Purpel, 1972).

In addition, clinical supervision rests on the notion that "teaching, as a complex interaction of the teacher's behavior, the learner's behavior, and content variables, is patterned" (Mosher and Purpel, 1972, p. 80). If the behaviors are regular rather than random, then teaching can be studied by classification and analysis.

Two further aspects are effectively considered together. Clinical supervision operates as if (a) teaching behavior can be understood and controlled, and (b) instructional improvement can be achieved by controlling (changing or modifying) certain behaviors (Mosher and Purpel, 1972; Huffman, 1973).

Clinical supervision also is based on the proposition that the supervisor-supervisee relationship can be one of mutuality. The supervisor's task is to secure the commitment of the teacher (not to coerce) and to increase the teacher's freedom to act self-sufficiently in the classroom (Moore and Mattaliano, 1970). This practice contradicts the general supposition that the supervisor (whether serving in a line or staff position) is above the teacher in the educational hierarchy. The teacher and supervisor work as colleagues.

Framework of Values

Goldhammer (1969) specified the values associated with clinical supervision. A primary value upon which clinical supervision is based is respect for individual human autonomy. This respect implies that self-sufficiency and freedom to act are goals for learners, teachers, and supervisors.

Further, inquiry, analysis, examination, and evaluation, especially when self-initiated and self-regulated, are espoused. Goldhammer (1969) sees these activities resulting in outcomes which are "inherently human, conceptually tough, grounded in intellectual humility, and based upon a determination to discover more about reality and to construct behaviors that are rationally related to such discoveries" (p. 55).

There is also belief in the high value of human compassion, patience, and sense of one's behavior and its impact upon others. Goldhammer (1969) stresses that immoderate behavior which fails to be compassionate will be self-defeating in terms of the purposes of clinical supervision.

The Model

While clinical supervision lacks the attributes of a theory (Cogan, 1973; Mosher and Purpel, 1972; Sergiovanni, 1976), the definition, propositions, and values are accompanied by a model.

Clearly, the space within which the model operates is the classroom. The individuals directly involved are the teacher and the supervisor. The predominate feature of the model is its process, the cycle of clinical supervision.

Because clinical supervision is a process model, this exposition of its content will focus on the point of initiation, the specific steps in the cycle, and the expected benefits. People in the process model are role takers; therefore roles will also be examined.

Initiating the Process

The person responsible for initiating the clinical supervision model is the teacher. Goldhammer (1969) stated that the desired clinical supervision was "basically teacher-initiated and consistent with independent, self-sufficient action" (p. 368). Cogan (1973) asserted that "it is in the teacher-supervisor dyad that the teacher learns that the supervisory program is [the teacher's], not the supervisor's" (p. 93). It is the teacher who, with aid from the supervisor, expresses the individual goals, problems, strengths, and weaknesses which become the objectives in the phases of the clinical supervision cycle. Indeed, in addition to beginning with the teacher, the process, as Cogan (1973) indicated, is "shaped to be congruent with the teacher's universe, with his [or her] internal landscape rather than that of the supervisor" (p. xii).

In the original clinical supervision setting, the teacher was in preservice training. As the model was generalized, inservice teachers assumed the same initiating responsibilities.

The Process

The process which specifies the tasks and activities is the cycle of clinical supervision. Sources vary in the number of stages and in the labels attached to the components involved (Goldhammer, 1969; Mosher and Purpel, 1972; Cogan, 1973; Boyan and Copeland, 1978), but the content is similar, with general emphasis placed on planning, observation, and evaluation. In all of these areas, the focus is upon surface behaviors: intentions and motivations are not probed. It is important to note that although the cycle is presented in a linear fashion, components are viewed as interrelated with and influenced by one another.

Cogan's (1973) description, which includes eight steps called "phases" will be used to present the cycle. Phase one requires establishment of the teacher-supervisor relationship. It is at this point that the supervisor establishes the clinical relationship with the teacher, explains the purposes and sequences of clinical supervision, and begins to help the teacher take on new roles and functions in the supervisory process.

During the next two stages, planning occurs. In phase two, the supervisor and teacher plan together a lesson, a series of lessons, or a unit. In phase three, the supervisor, with participation from the teacher, plans the objectives, process, and arrangements (including technical aspects) for the observation and data collection. The focus should be "the safe ground between trivial and overambitious changes in the teacher's behavior" (Cogan, 1973, p. 28).

Goldhammer (1969) indicates that these pre-observation activities serve primarily to provide a mental framework for the remainder of the supervisory sequence. They also help to reduce anxiety which often occurs in response to in-class, observational supervisory practices.

Phase four involves observation of instruction and takes place in the classroom. Data may be collected by notes recording classroom events verbatim (Goldhammer, 1969), by organizing around categories of pupil and teacher behavior (Mosher and Purpel, 1972), and/or by systematic observation using any combination of established techniques (Cogan, 1973; Flanders, 1976).

In phase five, following the observation, the teacher and supervisor analyze the teaching-learning process. This analysis is designed to make clinical supervision "less whimsical, less arbitrary, less superficial" (Goldhammer, 1969, p. 64) than previous approaches. Cogan (1973) indicates that this phase should deal with critical incidents and pattern analysis. It ultimately makes data useable and useful.

Planning the strategy of the conference is the major task of phase six. This may be handled by the supervisor alone or by the supervisor and teacher working together. The physical setting should be chosen to provide a convenient place and time to ensure privacy. The supervisor prepares for the conference but does not preplan the entire sequence of events.

The conference occurs in phase seven. Usually participants are the teacher and supervisor. It is at this point that the teacher and supervisor try to understand what has taken place in the classroom. The teacher begins to make decisions about his/her behavior and students' behaviors and learning. There is no prescription for the clinical supervision conference because, by design, "the conference defines itself in its context" (Cogan, 1973, p. 196).

When the teacher and supervisor decide on the kinds of changes sought in the teacher's classroom behavior, they enter phase eight, renewed planning. When they begin planning for further instruction and changes to be made, the sequences of the cycle resume.

Emphasis throughout this cycle is on instructional improvement through direct feedback in areas that are of concern to the teacher. The system does not center on rating forms or on items that are of interest primarily to the school, system, or supervisor.

Expected Benefits

The purposes—and therefore the expected benefits—of clinical supervision are improvement of instruction and development of the teacher. Improvement of instruction, though not defined, deals with the teacher's classroom performance (Cogan, 1973). The desired development of the individual yields "the professionally responsible teacher who is analytical of his [or her] own performance, open to help from others, and withal self-directing" (Cogan, 1973, p. 12).

In addition, the expected (though not openly stated) outcome of the process as it was used in preservice preparation was induction into the field of education and teacher certification.

Roles

The clinical supervision model prescribes rather than defines roles. The distinction between role definition and role prescription is important: role definition rests on a *normative* standard expressed in terms of the central tendency of a reference population, while role prescription involves a value statement regarding a desired state or goal (Miller, 1978). Therefore, because the roles of the teacher and supervisor are prescriptive, they reflect what the developers of clinical supervision believed should exist and do not neces-

sarily describe any already existing norms. Indeed, the ambiguities regarding tasks and personal qualities (Firth, 1976) and the supervisor's hierarchal rank over the teacher which are typical of most supervisory approaches are not part of clinical supervision.

In order to facilitate the processes of the cycle of clinical supervision, the teacher and supervisor are required to take certain roles; that is, to exhibit certain behaviors and characteristics. Some of the components of the roles are shared by both; some are unique to one or the other.

Both the teacher and the supervisor take part in conferencing, analyzing, and data gathering. They must perform these tasks as individuals but must share the results of their endeavors. Both are decision makers. Cogan (1973) indicates that the teacher and supervisor may "agree to disagree" or to try alternatives, but they must have "shared understandings about the decision and its implementation" (p. 28).

While both the teacher and the supervisor are required to instruct, the content of the activities varies. The teacher plans for lessons in the classroom; the supervisor plans for conferences. The teacher instructs students in the content of the curriculum; the supervisor instructs the teacher in the content and cycle of clinical supervision.

The activities and tasks of the teacher and supervisor are accompanied by descriptions of the interaction which should take place and personal characteristics of the individuals involved. Both individuals are, according to Cogan (1973), responsible for the "maintenance of agreeable and productive working relationships" (p. 94). Each is to give and receive support that is helpful and strengthening personally and professionally.

Cogan (1973) indicated that the clinical supervisor needs to be open, flexible, and careful in making judgments. Further, both task-oriented and person-oriented behaviors are to be exhibited "in an integrated fashion" (Cogan, 1973, p. 50).

Because the demands made on teachers are similar to the demands made on supervisors, it seems reasonable to suggest these characteristics are also required of the teacher. The fact that the teacher puts the process into motion indicates that he/she must also have initiative.

Summary

Clinical supervision is an in-class approach to instructional supervision which has as its goals improvement of instruction and teacher development. It is based on propositions which stress teaching as a behavior which is patterned and which can be controlled. The teacher and supervisor relationship is viewed as one of mutuality. The framework of values associated with the design includes respect for individual autonomy; espousal of self-initiated and self-regulated inquiry, analysis, examination and evaluation; and belief in the importance of human values.

The model associated with clinical supervision is a process model, the cycle of clinical supervision. The processes, which are initiated by a teacher who requests aid, involve conferences, observation, and analysis.

The roles of the teacher and the supervisor are prescribed (as opposed to defined) and include instructing, conferencing, analyzing, and data gathering as activities. Both teacher and supervisor are to be open, flexible individuals who are careful in making judgments. Each is to contribute toward a productive working relationship that benefits both.

The design of clinical supervision can be examined for adequacy and effectiveness in two ways: through research and through critical analysis.

Testing Clinical Supervision: A Review of Research

Denham (1977) noted that the relationship between empirical research and clinical supervision is a potentially important one: "The clinical supervision cycle . . . seems well suited to the kind of careful study and analysis that can provide the now absent data base for supervision as a discipline" (p. 35). At this point, however, the research related to clinical supervision is sparse and that which does exist reflects a lack of rigor often associated with a new field of inquiry.

Limitations

There is no recognizable pattern of research on leadership in the areas of instruction and supervision. Firth (1976) indicated that much of the research which has taken place has been limited for two major reasons. First, it has been based on the premise that what is done in education corresponds to what should be done. This is a questionable research basis since it reflects an a priori bias. As Harris (1963) indicated, description may not lead to improvement. Harris also pointed to a closely related problem when he differentiated between investigation of *usefulness* and evaluation of the *effectiveness* of educational practices.

Attempting to build general theory from "specific, isolated, idiosyncratic studies" (Firth, 1976, p. 331) was listed as a second major flaw in educational leadership research. It is somewhat discouraging to note that the same problem was delineated by Harris (1963) more than a decade earlier: "Exacting studies of supervision programs as distinguished from specific activities or isolated supervisory endeavors are almost nonexistent" (p. 131).

Research on in-class supervision as a specific area is even more

inadequate. Most of the work which has been done has been conducted by doctoral students for dissertations: there appears nowhere an ongoing line of research.

Findings

In order to use the findings of a small number of studies to test the tenets and contents of clinical supervision, this research review has the same organization as the exposition of the design of clinical supervision. It will report work that has been done regarding the propositions and values, the processes, the expected benefits, and the roles and relationships of the teacher and supervisor. Related research as well as research designed on clinical supervision will be included.

Propositions and Values

Several studies, though not specifically based on clinical supervision, support some of the basic tenets of clinical supervision.

Edgar (1972) reports an empirical study in which the autonomy attitudes of new teachers changed significantly ($p < .025$) more toward the attitude of the evaluators in situations where there was high affect between the new teacher and the evaluator than in situations where there was low affect. In Parsons' (1972) survey of 556 teachers in west central Ontario, respondents identified closeness of the supervisor to the teacher as a major factor in effectiveness.

The conference setting was the focus of studies by Lanning (1971) and Gordon (1976). Lanning (1971) examined the relationship between group and individual counseling supervision and three interrelated dependent measures: trainee perceptions of the supervisory relationship, trainee expectations of their own counseling relationships, and client perceptions of the trainee's counseling relationships. The results yielded little evidence that the methods were significantly different. They did indicate that more than half the variance in how a trainee expected to be perceived by clients was accounted for by knowing how he/she perceived his/her supervisor.

In a study by Gordon (1976), teachers in western New York and south central Alabama responded to two categories in a questionnaire: (1) the purpose of the one-to-one conference and (2) the

single behavior the teacher felt was most evidenced by the supervisor. Answers were categorized into one of five predetermined categories: listening, diagnosing, advising and informing, supporting, and information gathering. Results indicated that teachers perceive supervisors as being most effective when they are being supportive.

Herrick (1977) examined positive and negative aspects of the supervisory experience for supervisees. One of her conclusions has implications for clinical supervision: the supervisee's initial anxiety about evaluation diminishes as he/she finds that supervision meets needs for professional growth and has value for work with others.

Perception of supervisor behavior style and teacher morale was the focus of a study by Blumberg and Weber (1968) in which 210 inservice teachers described their supervisors' behavior using an adaptation of Flanders' categories and an incomplete morale test used by Suehr. Analysis of variance indicated that differences in perceived supervisor behavior style were related to morale scores in a statistically significant manner.

General research, then, indicates that the supervisor who is close and supportive is favored by teachers. Further, the way the supervisor is perceived affects the teacher's morale and the way the teacher expects to be perceived. These findings are compatible with the in-class and colleagueship components of clinical supervision.

In research which dealt specifically with clinical supervision, Eaker (1972) surveyed perceptions of clinical supervision by different educators. Respondents varied in professional position and experience (some had three years or less, others had more than three years). The sample included teachers and administrators in the seven largest school systems in Tennessee. Results led to the following conclusions:

1. Most teachers and administrators agreed with the basic assumptions of clinical supervision.

2. Although the teachers tended to agree with the procedure of clinical supervision, they agreed more strongly with the assumptions than with the specific procedures.

3. No firm conclusions could be drawn as to how teachers felt about being trained in observational techniques for the purpose of analyzing each other's teaching.

4. Administrators tended to agree more strongly with the assumptions and procedures of clinical supervision than did teachers.

5. There was insufficient evidence to conclude that there exists significant differences in views of teachers with three years' or less experience and those with more than three years' experience (p. 3998-A).

Arbucci (1978) used qualitative and quantitative analysis to study the relationship between the implementation of clinical supervision and the attitudes of teachers toward instructional supervision. Results showed that while there was a significant difference between control and experimental groups in amount of supervision, no significant difference was found in attitude scores.

Processes

The cycle of clinical supervision was the focus of one study. Turner (1976) used a case study approach in which she, in the role of supervisor, used the Goldhammer model with three elementary teachers in a variety of teaching-learning situations. The study confirmed the five stages (pre-observation conference, observation, analysis and strategy, supervision conference, post-conference analysis) as well as several problems described by Goldhammer (such as inaccuracy in supervisor's records) and supported Goldhammer's emphasis on rapport as an essential ingredient in the supervisory relationship. The case study was found to be a viable method for studying the supervision process.

Mershon (1972) focused upon the need to define more clearly analysis as used in clinical supervision processes. Using transcription of interviews held with 27 graduate students and four faculty members about analysis of teacher and student behavior, he derived 14 analytic subskills. Mershon emphasized that the array of subskills could be used to develop awareness and overcome deficiencies caused by insufficient data or inappropriate references. He stated also that "the quality and characteristics of each person's analytic process are unique" (p. 6793-A).

Expected Benefits

By design, clinical supervision is supposed to change the performance of teachers in the classroom. A related study which used

in-class data collection and four studies dealing with clinical supervision all report changes in teacher behavior in directions specified as desirable.

James (1971) conducted a study with student teachers which concluded that

> traditional supervision supplemented by opportunities for self-confrontation and self-evaluation via videotaped feedback of a student teacher's own classroom teaching behavior facilitated the development of the desired inductive-indirect teaching strategy to a higher degree than did traditional supervision alone or traditional supervision supplemented by viewing experienced teachers using the desired technique (p. 337).

In a study which examined the clinical supervisor as a resource to college teachers of English, Garman (1971) reported that four of five teaching assistants who received clinical supervision as well as a 12-week teaching seminar were able to design changes in their instruction. Of five teaching assistants exposed to only the teaching seminar, only one was able to make similar changes in instruction.

In B. J. Kerr's (1976) research, the desired instructional change was increased individualization. The study investigated the use of feedback data within a clinical supervisory model to facilitate the selection, implementation, and evaluation of individualized instructional processes by four elementary school teachers. The analysis of the data showed that the use of feedback data and teacher-and-student completed instruments helped the teachers to evaluate instructional processes and to select elements and instructional strategies for further individualization. Three of the four teachers, in response to assessment instruments designed to evaluate whether a degree of individualization was achieved in reading programs, referred not only to achievements in individualization but also to future goals.

Skrak (1973) attempted to determine whether the use of immediate secondary reinforcement during classroom observations would effect a behavioral change which was greater than the behavioral change effected by clinical supervisory practices which do not employ immediate secondary reinforcement. Three intern teachers and two experienced teachers were involved in the two phase project. For two of the three intern teachers and both of the experienced teachers successful results were achieved utilizing the secondary reinforcers. Skrak's conclusions were cautious, however:

> The use of immediate secondary reinforcement during teaching observations in clinical supervision is a valuable tool which can be employed to assist teachers in their development of desirable behavior patterns. However, the use of immediate secondary reinforcement during observations does not guarantee a greater degree of behavioral change than do clinical supervisory procedures which do not employ such immediate feedback. Much depends upon the personality of the teacher, his philosophy of human behavior, his ability to perceive the cues which his teaching environment provide him, and the manner in which he and his supervisor relate (p. 1140-A).

Krajewski (1976) divided a sample of 41 MAT interns into an experimental group of 20 and a control group of 21. All received regular supervision visits from the university supervisor. The experimental group also received five clinical supervisory visits during which their teaching was subjected to video analysis and Flanders' Interaction Analysis. The experimental group, as indicated by analysis of variance, became more indirect (as was desired) in their approach, talked less, praised more, and used student ideas more. The inverse variation between teacher talk and student talk indicated that students initiated more participation and interaction in the classroom. Composite results of the study led to the conclusion that the MAT experimental group exhibited better teaching and more accurate post self-perception evaluation of their teaching than did the control group. Krajewski proceeded to develop a teacher guided self-improvement model based on his findings.

Teacher development, another expected benefit of clinical supervision, was one of the main foci of a study by Shuma (1973). The purpose was to investigate clinical supervision which emphasizes the establishment of a helping relationship (based on congruence, unconditional positive regard, and empathic understanding) and the use of the conference format of 12 sequential steps developed by John L. Morgan and David W. Champagne of the University of Pittsburgh and to explore its effects upon: (1) change in student perception of the class and of the teacher-student relationship and (2) teacher growth whereby teachers come to see themselves differently and become more confident and self-directing.

The findings indicated there was a statistically significant change in student perception (1) of the class with regard to the teacher's organization of tasks, the proximity of the pupils' objectives to the teacher's objectives, the teacher's inclusive behavior, the teacher's

procedures for evaluating learning, the teacher's response to pupils' communicative behavior, the pupils' productive behavior and (2) of the teacher-student relationship after clinical supervision which had emphasized the establishment and maintenance of a helping relationship and the Morgan-Champagne Supervisory Conference format. There was no statistically significant change in the perception of the class and of the teacher-student relationship when there had been no supervision which emphasized the aforementioned conference and relationship behaviors. Further, the use of clinical supervision and the Morgan-Champagne Supervisory Conference resulted in teacher growth whereby the teacher became more confident and self-directing.

Teacher and Supervisor: Roles and Relationships

Of the studies reviewed which dealt with the teacher and supervisor, two dealt with the supervisor's role and four dealt with the teacher-supervisor relationship.

The supervisor's role. Pierce (1975) studied the relationships between the supervisor's verbal behavior (pedagogical moves) with teachers during the supervisory conference, and aspects of the supervisor's managerial traits, motivational needs, and personality. Correlations on data from coded audiotapes and responses to Ghiselli's Self-Inventory of Managerial Talent by 28 supervisors indicated that pedagogical moves of structuring and reacting were significantly ($p \leq .01$) and positively correlated to supervisors' decisiveness. Responding moves were significantly ($p \leq .05$) and negatively correlated with self-assurance.

In a study which was descriptive and heuristic, Cook (1976) examined the questions of whether supervisors showed changes in perception and behavior during their training with particular regard to the variables of genuineness, empathy, and respect and whether there were trends or patterns in the changes. Case studies were based on quantitative analysis of attitudes and behavior as indicated on the Barrett-Lennard Relationship Inventory and the Blumberg System for Analyzing Supervisor-Teacher Interaction and qualitative data based on class meetings, papers submitted for the supervision course, and interviews. Five of the six supervisors studied gave evidence of increasingly accurate perceptions of classroom events. In

most cases, behavior was related to perception. Genuine acceptance of the complex supervisory role and other-centeredness were interrelated. Cook characterized changes as "going beyond academic learning or skill acquisition" and involving changes in self-concept within the professional role.

Teacher-supervisor relationship. In a phenomenological study of the supervisory experience in general, Squires (1978) reported a number of positive aspects of the supervisor-supervisee relationship. He specifically noted that as the supervisee becomes more autonomous, the relationship comes to resemble that of colleagues.

Zonca (1972) explored effects on an intern teacher of openness (including traits of disclosure, directness, and honesty) in a clinical supervisory relationship. Participants were one Spanish intern teacher and one master teacher. From the findings, the writer concluded that the condition of openness contributed, in part, to the intern teacher's overall development. It had positive effects on her attitude, ability to analyze classroom teaching behaviors, openness with the master teacher, and ability to progress toward self-supervision. The only area where the condition of openness did not seem a positive effect was in the ability of the intern teacher to analyze changes in her classroom teaching behaviors.

In another study which included the teacher-supervisor relationship in clinical supervision, T. G. Kerr (1976) gathered empirical data to measure the relationship among teacher attitudes toward components and assumptions of clinical supervision, teacher levels of open-mindedness, and change in a classroom teaching pattern among teachers who have experienced the clinical supervision process. Results indicated that the more open-minded the teacher the greater the willingness to engage in direct two-way communication with the supervisor. Findings also indicated that teachers were able to move from direct to more indirect teaching patterns of high or low dogmatism scores. Recommendations included educating both teachers and supervisors in the clinical supervision process while making supervisors more aware of those qualities teachers find most valuable in a teacher-supervisor relationship.

Reavis (1977) investigated possible differences in verbal exchanges between supervisors and teachers when traditional supervision and clinical supervision were contrasted. Clinical supervision was hypothesized to create a more democratic relationship as re-

vealed by verbal interaction. Seven supervisors each worked with one teacher in clinical and one teacher in a traditional method. Tapes of conferences were made and coded by trained observers. Univariate analysis of variance revealed a significant difference between the treatment groups in two ("supervisor accepts or uses teacher's ideas" and "supervisor asks for teacher's opinions") of 15 categories assessed. Reavis (1978) in discussing these results stated that the verbal exchanges are significantly different, favoring clinical supervision in two dimensions, and "these may be highly significant in promoting teacher motivation for classroom behavior change" (p. 584).

Summary

Taken together, these studies yield some findings in support of the clinical supervision model. There is evidence which points to validation of the model (Turner, 1976) and indications that the model's tenets and processes are compatible with the desires of teachers and administrators (Eaker, 1972).

In the clinical supervision setting, changes in the teacher's classroom behavior occurred in directions designated as "desirable" (Garman, 1971; Skrak, 1973; B. J. Kerr, 1976; Krajewski, 1976). There was evidence of teacher growth in self-confidence and self-direction (Shuma, 1973).

Examination of the teacher's and supervisor's roles has shown that the supervisor's role involves self-concept as well as cognitive learning (Cook, 1976) and that open-mindedness on the part of the teacher is needed (T. G. Kerr, 1976). Within the supervisor-teacher relationship, which Reavis (1977) found to be more democratic in clinical supervision than in other supervisory approaches, rapport (Turner, 1976) and openness (Zonca, 1972) have been revealed as important characteristics. Shuma (1973) demonstrated that the nature of the teacher-supervisor relationship affected the teacher-student relationship.

Needs

While findings and indications can be summarized, no general conclusions can be drawn from the available research: the amount

and quality of research is insufficient to support generalizations concerning the model.

In order to overcome the methodological inadequacies of current work, future studies should have better sampling techniques. Most of the cited studies which are specific to clinical supervision have very small samples and therefore have limited generalizability although they do provide suggestions for potentially fruitful research directions. Further, most of the samples, though not labeled as such, appear to be samples of convenience, often including the investigator as both subject and observer.

Future investigations must also overcome problems in design which characterize much of the available work. Specifically, attention should focus on eliminating flaws caused by lack of care in ensuring that (1) clinical procedures were followed and (2) participants were unaware of expected results (Reavis, 1978). Care should be given to ensure proper treatment of control groups when clinical supervision is applied to the experimental group: whether there should be no supervision or whether traditional supervision should be used is a question that affects the interpretation of results. Further, because of the possibility of the Hawthorne effect being associated with some of the data-gathering devices used in clinical supervision (Reavis, 1978), any differences in results must be interpreted carefully.

Strengths and Weaknesses of Clinical Supervision: An Analysis

Exposition of the clinical supervision model and scrutiny of research lead to an analysis of strengths and weaknesses based upon the literature and research as it exists at this point in time. The purpose of such analysis is not to advocate or reject clinical supervision but rather to look at its utility and efficacy. This examination of clinical supervision is arranged around the following questions which appear cogent and which force considerations from several perspectives:

What are the adequacies and inadequacies within the design of the clinical supervision model?

To what extent is the model applicable to schools as they exist?

To what extent can it be and has it been varied and adapted?

What is the relationship between clinical supervision and planned change?

How does the practice of clinical supervision compare with prognostications?

• *What are the adequacies and inadequacies within the design of the clinical supervision model?*

The values and propositions upon which clinical supervision is based resonate well with democratic ideals. The notion of participation by both parties involved—the supervisor and the teacher—and the idea of mutuality in the colleague relationship fit comfortably with the rights and responsibilities of citizenship. They also display a kind of integrity and respect which contrast favorably with Commager's (1975) assessment that "much of public education today is a massive demonstration in hypocrisy" (p. 11).

Further, the intents and purposes appear to respond to some expressed supervisory needs. Blumberg (1974) specified that in order to turn the supervision process into a productive venture three conditions are requisite: (1) the teacher must desire aid, (2) the supervisor must have or be able to locate resources required, and (3) the interpersonal relationships must enable the teacher and supervisor "to give and receive in a mutually satisfactory way" (p. 10). By design, clinical supervision deals with two of these three conditions. It focuses on those problems with which teachers want help and includes a teacher-supervisor relationship which is collegial.

The initiation of the model is, at first glance, clear: the teacher requests aid. This clarity must not be mistaken for adequacy. Teachers vary widely in personal and professional styles. Not all teachers are cognizant of their instructional needs; nor are all teachers willing and able to ask for support. The heart of clinical supervision is its process and accompanying roles, but how is the cycle to begin if a teacher wants aid but does not request it? Further, how is the supervisor to handle situations in which the teacher neither wants nor asks for supervisory support? The specificity of the step in which the processes are initiated gives the model internal consistency, but it does not ensure that supervisory support will be given in cases where need is either unrecognized or not publicly admitted.

Like the initiating step, the cycle of clinical supervision is specific. It has a clearly delineated sequence of phases which provide for interaction between teacher and supervisor and which emphasize the classroom setting. The cycle appears to include crucial content. Blumberg (1974) reports that both teachers and supervisors find their interpersonal transactions with each other to be the cause of most problems in supervision. Certainly, the phases of the cycle deal overtly with these transactions and provide a structure for specifying and accomplishing tasks.

Close examination reveals difficulties with the progression of phases. Though developers say that the phases which are presented as linear may be interrelated, the nature of any order or relationship other than the linear sequence is not included in the model.

Further, though the general content of the cycle is outlined, the content of specific individual phases is not always clear. Ryan (1971) points out, for example, that the processes do not include

descriptions of the human relations and counseling techniques used by effective supervisors.

The scope of the clinical supervision processes is attacked by Harris (1976) who states that the model may not provide for use of available procedural alternatives. Specifically, modeling, skill building, and group experiences may be excluded. It appears that Harris (1976) encourages explicit addition to the model although such experiences are not excluded from the model as it has been articulated.

In contrast to the specificity of other components of clinical supervision, the expected benefits are ambiguous. While there are general indications of the meaning of teacher development (the teacher becomes self-analytic, self-directing, and open to help), the term *improvement of instruction* remains undefined.

The boundaries of instructional improvement are clear: the model has goals in only one major area of the teacher's responsibility: teaching. It does not involve school functions (hall duty), organizational duties (calling roll), or employee duties (arriving on time) (Moore and Mattaliano, 1970).

Within these boundaries, however, there remains a lack of clarity. Cogan (1973) uses the terms "teacher's classroom performance" and "teacher's classroom instruction" interchangeably (p. 9). Sergiovanni and Starratt (1979) point out that this is not unreasonable: "Practically speaking, if we are interested in improving classroom instruction, we must start with the teacher" (p. 287). Cogan (1973) indicates that instructional improvement is not limited to one style of teaching: he says that "good teaching may take manifold forms" (p. 55). Yet, there is no specification of what "good teaching" is or what happens as instructional improvement starts with the teacher.

Though clinical supervision should not be confused with teacher effectiveness (Flanders, 1976), resolution of questions regarding validation of improvement of instruction in terms of student change needs to be considered as an outcome. However, the issue is one for debate. Goldhammer (1969) sees validation in terms of student change as a way of viewing the teacher as only an "intervening variable" (p. 364), while Denham (1977) views it as an important outcome which needs to be clearly related to the supervision process. The issue should be considered for it is at the heart of the evaluation process.

The lack of a specific definition of *instructional improvement* is an inadequacy in the model which currently makes the clinical supervision process only as responsible and effective as the teacher and supervisor whose duty it becomes to supply definitions. Making *instructional improvement* a clear and precise term will be no easy task.

There is now evidence that teacher behaviors which are inappropriate and undesirable in one setting are effective—even appropriate and desirable—in another (Medley, 1977). Perhaps improvement of instruction can be approached through role prescriptions for students. Prescription of roles provides a wider range of potential criterion behaviors than does a simplistic product model which emphasizes only specific narrow skills. If student role prescriptions were established, then improvement of instruction could be defined in terms of teacher behaviors which encouraged assuming those roles. This would allow the specific behaviors of teachers to vary according to setting and population.

Importantly, any definition of *improvement of instruction* in the clinical supervision model will have to emphasize process rather than product. That is, it will have to deal with the magnitude and direction of change (Miller, 1979) rather than with the establishment of absolute criterion by which to determine whether a product came to exist.

Another ambiguity associated with outcomes is the failure of the model to distinguish between expectations for preservice and inservice teachers. Yet, induction *into* the profession is quite different from on-the-job improvement of one *in* the profession. The ends are so different that one wonders whether the means ought to be different.

The prescribed roles accompanying the clinical supervision model alleviate many of the problems with role descriptions that frequent the literature. For example, in comparison to the circular definition offered by Harris (1975) that a supervisor is "a professional person whose major responsibilities are in the supervisor function area" (p. 106), the clinical model offers a clearer delineation of roles.

A more clearly specified role with accompanying tasks can reduce the tendency of supervisors to perform functions with which they feel comfortable though many of these are mundane or unrelated to improvement of instruction (Huffman, 1973). It also helps

turn the trend from use of role-titles for enhancing imagery to performance identity (Eye, 1975a).

In contrast to other supervisory techniques in which the only visible vulnerability is that of the teacher, clinical supervision brings open for scrutiny potential errors in the supervisor's perception and analysis. In thus creating mutual vulnerability, it gives both the teacher and the supervisor rights and responsibilities in a manner which, in effect, sets up a system of checks and balances. It does not, however, provide for external supervision of the supervisor.

The collegial relationship provides a new role for teachers. In addition to allowing them to be participatory and making vulnerability shareable, it requires them to make professional judgments. It allows them the academic freedom to make decisions regarding their classroom instruction and thereby eliminates an area of potential conflict between teacher and supervisor (Munnelly, 1970).

Clinical supervision demands much of the teacher. Though the cycle allows for strategies to fail without individuals failing (Goens and Lange, 1976), it is important to note that the personal, individualized, intense approach of clinical supervision makes high demands in the areas of motivation, intelligence, and emotional stability (Harris, 1976). These demands may point to the need for greater diversity in the ways in which the teacher participates in the clinical supervision process.

Though roles in the clinical supervision model are comparatively well delineated, the relationship between roles is not clearly specified. The roles of supervisor and supervisee fit the definition assigned to complementary roles: "a role is complementary to another when the function prescribed by the first must be stated in terms of the second and vice versa" (Miller, 1978).

Miller explains that there are several kinds and forms of role conflict:

> (1) *Intra-role conflict* has two forms arising from different role expectations emanating from two or more complementary groups, (a) within one complementary group, and (b) between complementary groups. (2) *Inter-role conflict* occurs when expectations differ between two roles held simultaneously by one individual. (3) *Personality-role conflict* occurs when the individual's personality does not fit with role expectations (pp. 4-5).

Resolution of conflict must be approached as a function of the

type represented (Miller, 1978). Intra-role conflict is resolved through mediation and the redevelopment of a social consensus. Inter-role conflict may be resolved by the individual vacating one role or moving role functions apart in time and/or space. Personality role conflict is usually resolved by the individual denying the role to one's self.

The avenues for specific resolution of any of the kinds of conflict which appear inevitable in relationships involving complementary roles are not contained in the clinical supervision model.

Specifications of skills as well as methods of conflict resolution are needed. Krajewski (1977) indicates that skills needed in the supervisory process by supervisors and teachers fall into three categories: technical, human relations, and conceptual (knowledge). The clinical supervision model touches on some of the basic requirements in the areas of technical skills and human relations in its cycle of clinical supervision and prescription of roles. It does not clearly specify skills in any area, and it totally excludes from consideration the cognition needed. There appears to be an assumption of supervisor competence and teacher ability. Prerequisite skills and skills to be acquired need to be identified in order to clarify the model.

A general inadequacy of the model, which may in turn cause some of the other inadequacies, is the lack of any specified limitations as to the population for which the model is intended. At the present time, clinical supervision seems to be presented as a global approach for use with all teachers everywhere.

In summary, the clinical supervision model contains both adequacies and inadequacies. It is a humane approach which appeals to the values of many. Presentation of the design of clinical supervision —especially the cycle and roles—is clear in its general outline.

The surface clarity and specificity of the design, in many instances, does not withstand close scrutiny. Content of phases within the cycle and ways of resolving role conflict need specification. In the process initiation, the model is too simplistic as it fails to allow for the heterogeneity of teachers. The relationships among phases within the cycle are not described. The intended benefits lack definition. Overall, the model seems to lack clarification of content and specification of limitations.

• *To what extent is the model presently and potentially applicable to schools as they exist?*

The clinical supervision model, with its adequacies and inadequacies, presents one view of what should exist in instructional supervision. An important consideration is how this view, this ideal, relates to schools as they are. Wilhelms (Foreword to Cogan, 1973, p. ix) states that "there is a ring of reality to clinical supervision" and that "schools are dealt with as they are." Yet, the reality is that clinical supervision has not been widely used in schools or does it appear to completely fit into the current schemes of operation.

Krey, Netzer, and Eye (1977) indicate that clinical supervision is "one technique within the total scope of supervision rather than a complete approach to the supervisory function" (p. 16). It deals only with in-class supervision as a complement of out-of-class supervision (Cogan, 1973). It tangentially deals with some out-of-class issues. There is, for example, a relationship between curriculum development and clinical supervision because teachers get involved in what they teach (Mosher and Purpel, 1972). Other areas, such as the actual writing of curriculum, development of procedures for reporting to parents, and total program evaluation, are totally excluded (Cogan, 1973). If clinical supervision is to be useful in schools, the out-of-class duties traditionally associated with supervision must be dealt with in ways compatible with the design of clinical supervision.

Some of the requirements and limitations of clinical supervision give the model clarity and consistency but do not mesh well with the current situation in the educational world. The exclusion of evaluation and the elimination of administrators as supervisors are two apparently interrelated specifications which limit the utility of the clinical supervision model in schools.

Some see as healthy the clinical supervision approach which, in distinction to general supervision, separates evaluation and analyses of instruction (Goens and Lange, 1976; Sergiovanni, 1977). On the other hand, it seems impractical to leave unaddressed the question of evaluation, which is indeed a pressing one in a society increasingly interested in "getting its money's worth" and productivity.

This impracticality does not have to render the entire design inapplicable to schools. It is plausible that the conflict over evaluation and the strong stand by clinical supervision proponents are

rooted in history and semantics. Ryan (1971) points out that originally supervision had two purposes: aid and evaluation. Evaluation was, as the history of supervision indicates, primarily an inspectional task which took high priority and which could hardly be deemed a helping function.

This historical emphasis on inspection is complemented by the connotation of *evaluation* which brings to mind ratings, employment, and tenure. These meanings, which stress a finality of judgment—which are, in essence, summative—are obviously inconsistent with the purposes and design of clinical supervision.

However, the denotation of the word alters the situation. To paraphrase Bloom, Hastings, and Madaus (1971), evaluation is the systematic collection of evidence to determine whether in fact changes are taking place in persons as well as to determine the amount or degree of change in individuals. The denotation allows evaluation to be formative, for it to emphasize "ongoing growth and development" (Sergiovanni and Starratt, 1979, p. 286).

Formative evaluation is consistent with the design of the clinical supervision as a process model and with certain demands for accountability. Sergiovanni and Starratt (1979) indicate that teachers are held accountable in a professional sense by formative evaluation. He distinguishes between professional and occupational accountability:

> Professional accountability is growth-oriented and implies a commitment to consistent improvement. Occupational accountability is not growth-oriented at all, but merely seeks to meet some predetermined standard (p. 287).

If analysis is stressed as a major component of clinical supervision, then both the historical and semantic bases for separation of evaluation can be responded to without destroying the integrity of the design of clinical supervision. One *can* analyze and aid. One *can* use the material gathered through analysis to determine changes—that is, to provide formative evaluation—without being an arbitrary rater.

Further, the inclusion of evaluation as part of the clinical supervision model has the potential for changing the environment associated with evaluation from one of "suspicion, fear, and mistrust" to a "problem-solving atmosphere" (Goens and Lange, 1976, p. 20).

Without the inclusion of evaluation, the clinical supervision design has a range so narrow that it does not respond in realistic

ways to the demands made on schools. The inclusion of evaluation seems feasible from a philosophical viewpoint and attractive from a practical viewpoint.

The exclusion of evaluation in the current design appears related to the requirement that administrators, particularly principals, not serve as clinical supervisors. Cogan (1974) indicates that administrators have a part in the supervisory program: they can support, show enthusiasm, interpret, schedule, and coordinate. They are not to engage in supervision as such.

Cogan's separation initially makes sense in terms of the connotation of evaluation. If a principal is going to rate a teacher, the teacher wants to display and emphasize strengths rather than needs; yet the supervisor must deal with needs. It is interesting to note, however, that in a survey in western New York state, 56 percent of a sample of teachers felt that a building principal should spend 35 percent of the time in supervision (Heichberger and Young, 1975).

It may be that the definition rather than the separation of duties is of prime importance. Clinical supervision might have high utility if modified so that those employed as principals could assume the role of clinical supervisor.

In order for there to be consistency with the philosophy and model of clinical supervision, the status differentials which exist in other relationships between principal and teacher would have to be set aside. While the principal and teacher might not be equals in many settings, in the exchange regarding the teacher's classroom performance and throughout the cycle of clinical supervision, the contribution of each must be equally important.

Given this perspective, it seems that colleagueship would, in general, be no more difficult to achieve between a principal serving as clinical supervisor and a teacher than between another clinical supervisor and the teacher. The ideal of colleagueship as presented in the design of clinical supervision is not easily reached under any working circumstances. Indeed, there is disagreement as to whether it can be achieved at all.

Osborne and Hurlburt (1971) attack the idea of exchange and equality. They assert that, despite efforts of authors to view the relationship as one of equals, a status differential still exists. McGee and Eaker (1977) pointed out that the collegial model is realistic and

promising because of four current trends. The increased use of team teaching, the increased popularity of clinical approaches to supervision, the general upgrading in training of all teachers, and the growing stability of teaching staffs are all cited as factors contributing to the collegial relationship. One is, in effect, left in a quandary as to whether collegiality can and does, in reality, exist.

Allowing existing administrators to function as clinical supervisors would help alleviate the costs associated with clinical supervision. These costs are high. Training of clinical supervisors is expensive. Further, because clinical supervision demands more time, energy, and skill than is usually required of a supervisor (Ryan, 1971), fewer teachers can be served in a given period than when traditional supervisory methods are used. If new personnel have to be hired to serve as supervisors, the costs of using clinical supervision become prohibitive for most schools and systems.

One population for which the clinical supervision model appears to have the potential for positive impact in the current school settings is tenured, experienced teachers. Traditional supervisory programs are often inappropriate for experienced teachers who need "something more imaginative, more forceful, more reciprocal and involving, perhaps a little less embarrassing and humiliating" (Goldstein, 1972, p. 393). Goldstein suggests that a goal-oriented approach is needed. Clinical supervision is goal-oriented in that teacher and supervisor specify targets and purposes which guide the observation and analysis during the cycle. It is involving and avoids embarrassment and humiliation. That the approach can be adapted for experienced teachers is demonstrated in a presentation of clinical supervision for inservice teachers (Cogan, 1976).

Thus, it appears that clinical supervision has great potential to be useful in the schools, but in its current state it is not readily applicable primarily because of its costs in time, money, and personnel; its exclusion of evaluation; and its separation of administration and supervision. If the model can be modified to meet these realities without sacrificing its own internal consistency, then clinical supervision may be of high utility to the practitioner.

- *To what extent can it be and has it been varied and adapted?*

Careful analysis demands a search for and presentation of variations and adaptations of clinical supervision in addition to ex-

amination of the original design. Development of theory associated with the clinical supervision design was explored by Sergiovanni (1976). Sergiovanni's theory includes "the concept of surfacing dilemmas between teacher intents and their corresponding antecedent assumptions and beliefs, and teacher intents, assumptions, and beliefs that are inferred from the teacher's behavior and artifacts generated by that behavior" (pp. 22-23).

Other variations deal with the implementation of the clinical supervision model. Simon (1977) described employing a frequently-used analysis technique to a very particular aspect of teaching. He advocated the use of videotaped sequences to help teachers look at beliefs versus practices as a technique in clinical supervision.

In a more comprehensive suggestion, Riechard (1976) used the basic concepts of clinical supervision to develop a model for training resident clinical supervisors. Riechard asserted that the model is a way to facilitate meeting demands of competency-based teacher certification programs.

Another in-school plan utilizes team teaching situations to develop a model of clinical supervision based on team planning and teaching and peer observation and analysis (McGee and Eaker, 1977). This approach is advocated as one that leads to collegiality and self-sufficiency and reduces anxiety over supervisory observations. Whether this model could operate as proposed should be examined carefully. Marcotte (1972) cited results of the Triple T Project at the University of Washington which indicated that supervisory responsibilities were not compatible with teaching demands.

Developers of the empathetic rational action (ERA) training model describe the ERA process as "a variant and refinement of prior process models for clinical supervision" (Graves and Croft, 1976, p. 79). The system emphasized empathetic rational action by including empathy as a characteristic of all actions of the supervisor and by using a team relationship between teacher and supervisor which is empathetic and rational and which facilitates lines of communication, reduces anxieties, and promotes negotiation and acceptance of each other's values.

Application of the concept of management by objectives to clinical supervision was the focus of an article by Burke (1977). Burke presented four basic kinds of objectives (student process, student

terminal, teacher process, and teacher terminal) and emphasized teacher instructional behavior as a teacher-process behavior. He specifically discussed the involvement of mutual participants in setting four categories of objectives: routine objectives, emergency objectives, creative objectives, and personal growth objectives. He advocated management by objectives as a method of improving clinical supervision.

Cogan (1964) described the potential for clinical supervision by groups and its experimental use in the Harvard summer program. He emphasized that supervising by groups increases efficiency because specialists work in concert. It also reduces the effects of individual bias. Further, the persuasive power of the group is greater than that of an individual. Professional advantages of clinical supervision by groups include encouragement of specialization and improved distribution of supervisory labor.

Melnik and Sheehan (1976) reported the implementation of the clinical supervision model through the establishment of the Clinic to Improve University Teaching at the School of Education of the University of Massachusetts. The clinic used trained outside observers to work in the supervisory capacity with faculty members. Results indicated faculty acceptance of the procedure and reported changes in teaching behaviors.

The number of reported variations is small. It is interesting to note that both postulation of ideas and actual uses of the model are reported. Further, both the theoretical potential and practical application are explored.

• *What is the relationship between clinical supervision and planned change?*

In the original clinical supervision model and in variations thereof, there is emphasis on improvement of instruction. Because of this interest in instruction, the supervisor is by implication also interested in change (Unruh and Turner, 1970). Indeed, supervisors of instruction placed "leadership for change" as a top priority concern in a survey by the Association for Supervision and Curriculum Development (ASCD Working Group on Supervisory Practices, 1976).

The supervisor's concern is in keeping with widespread interest in change. Zaltman and Duncan (1977) indicate that because of the

consequences of change or lack of change, "there is a great interest in managing change to maximize its benefits and minimize its unfortunate effects" (p. 4).

Change can be defined as "the relearning on the part of an individual or group (1) in response to newly perceived requirements of a given situation requiring action and (2) which results in a change in the structure and/or functioning of social systems" (Zaltman and Duncan, 1977, p. 10). Planned change is brought about through deliberate and determined efforts. The interventionist or change agent in planned change "assists a system to become more effective in problem solving, decision making, and decision implementation in such a way that the system can continue to be increasingly effective in these activities and have a decreasing need for the intervenor" (Argyris, 1970, p. 16). According to these definitions, the clinical supervision model deals with change, especially planned change, and the clinical supervisor serves as interventionist or change agent.

Certain characteristics of the clinical supervision design make it particularly conducive to planned change processes. First, the fact that clinical supervision deals with in-class events is significant. Cogan (1973) indicates that in the history of American education the point at which new teaching techniques have faltered has been at the point of application—in the classroom. Because new teaching techniques, or any innovations, are neither good nor bad, there is no reason to suggest they should all be adopted for use. The fact that the point at which adoption (or rejection) occurs is apparently the areas within which clinical supervision operates does point to the potentially strong link between the supervisory process and change.

A second relationship between change and clinical supervision involves personal aspects. Unruh and Turner (1970) stress the mutuality of the relationship needed for change: "To produce realistic and lasting change, supervisors and teachers must accept each other's strengths and contributions to the instructional program" (p. 281). Clinical supervision and its model, which stresses colleagueship, move toward the kind of mutuality associated with change.

A third characteristic of clinical supervision which appears to promote the change process is the way in which the model is initiated. Frymier (1976) notes that from his perspective the greatest incentive for change in today's public schools is the "promise for an increase

in personal satisfaction" (p. 45). Because the cycle of clinical supervision begins with the teacher specifying areas of concern and need, there is great likelihood that the process will deal with areas that are important to the teacher, and that opportunities and suggestions for improvements will be in the areas which can produce the personal satisfaction associated with change.

The emphasis on the individual teacher is potentially detrimental as well as potentially beneficial to the change process. A balance must be achieved. Zaltman and Duncan (1977) indicate that change programs should not be dealt with only at the individual level because the individual is greatly affected by others and the larger culture. Certainly there is nothing in the clinical supervision model to ensure consideration of a larger community.

Other aspects of the change process which are not dealt with in clinical supervision are pointed to in a complete change process strategy for supervisors outlined by Harris (1977) which includes three stages: I. Alternatives and Awareness; II. Adopting; and III. Installing. Though some aspects of each stage could be addressed in conjunction with the cycle of supervision (for example, awareness in stage I, trial activities in stage II, and revision of structures in stage III), most aspects either deal with out-of-class activities or are more properly addressed in models other than one promoting colleagueship because they include many individuals of varying status and power.

Within the supervision model, the clinical supervisor's role can involve very specific change agent functions relating to the "productive management of instructional innovations" (Cogan, 1976, p. 12). These include, according to Cogan:

1. Participation with teachers in the selection of instructional innovations which are useful and appropriate.

2. Developing a strategy to provide a fair and thorough test of innovations.

3. Developing among the faculty a commitment to testing and experimentation.

4. Helping to remedy and reverse failures often associated with new patterns of instruction.

5. Matching teachers to innovations by (a) helping to select

teachers likely to fit demands of certain innovations, (b) aiding them in consolidating new behavior, and (c) when necessary, helping to counsel them out of positions.

6. Supporting worthwhile innovations until new procedures become integrated into previous routines.

7. Preventing intrafaculty tensions.

It appears that the aspects of clinical supervision which might foster the change process are the in-class setting, the colleagueship, and the initiation of the clinical cycle by the teacher. There is within the model the potential for the supervisor to serve as change agent or interventionist through specific activities. The exclusion of out-of-class considerations and the potential for narrowing all interest to the individual upon whom the cycle is focused are aspects of clinical supervision which are not compatible with the change process. Thus, clinical supervision may be useful in limited ways to individuals promoting planned change. It is not a complete approach to planned change.

• *How does the practice of clinical supervision compare with its prognostications?*

In the final chapter of his book, *Clinical Supervision*, Goldhammer (1969) included "forward glimpses" in which he envisioned the potential of clinical supervision. Looking at the extent to which this potential has been realized is a helpful analytical technique: it reveals what *has* been done.

Goldhammer foresaw extensive use of the clinical model: he described the approach and components of clinical supervision as "realistically feasible to establish and disseminate" (p. 368). Yet there is indication of only limited application of the model. Mattaliano (1977) specified three reasons that use of clinical supervision has not become widespread: (1) the complexity of the process, (2) the lack of clearly identified competencies for performance, and (3) the sparseness of the literature.

Knowledge about how to train supervisors and how to administer supervision and training in school settings as well as development of "solid curriculums" were needs outlined by Goldhammer. Some clinical supervisory training programs have been developed, and the competency-based movement has emerged as a major attempt at

structuring curriculums (and certification processes in many states). McCleary (1976) pointed out the compatibility between clinical supervision and the competency-based movement: competencies can be inferred from the definition of clinical supervision. Boyan and Copeland (1978) have designed a training program to develop these specific competencies. These attempts may be based in current fads. Certainly the efforts are limited in scope. Training, administration, and development needs still exist.

Model refinement and research were the two major areas of potential exploration to which Goldhammer pointed. There have been studies dealing with model validation and there have been attempts —through thought and implementation—to create variations of the clinical supervision model. Yet, there has been a small amount of work done. Perhaps the limited quantity is the result of an inappropriate assessment of the potential involved. Sergiovanni (1976) clarifies the problem:

> I believe that clinical supervision at present is too closely associated with a workflow—a pattern of action—and not associated enough with a set of concepts from which a variety of patterns could be generated. The intellectual capital inherent in clinical supervision is in my view more important than its workflow as articulated into steps, strategies, and procedures (p. 21).

Likewise, the available research is lacking, as has been previously indicated, in both desired quality and quantity though over a decade ago Goldhammer declared the time "ripe for research" and called for research that was clinical and idiographic.

Therefore, much of the potential envisioned by Goldhammer in the first major book on clinical supervision has not been capitalized upon. The expressed needs have in some cases been addressed, but they have not been resolved. What is done in practice compares unfavorably with what was prognosticated.

Implications for the Future

An obvious question which follows recognition of the mismatch between envisioned potential and practice deals with how the potential of clinical supervision can be realized. The presentation of the design and the research as well as the analysis of clinical supervision have all pointed to areas which must be addressed by theoreticians and practitioners. The immediate future of clinical supervision needs to be one of discovery, clarification, and, perhaps, modification.

There are a number of assertions in the design of clinical supervision. The following questions which are generated from these assertions suggest research potential:

1. Does teacher participation in the supervisory process make a difference in
   a. how a teacher feels about supervision?
   b. teacher behavior?
2. Can instruction be better improved by giving feedback to a teacher on aspects of instruction that are deemed important to a teacher than by providing feedback on items on a rating scale established by another party (supervisor, administrator, school system)?
3. Do analytical discussions with supervisors help teachers improve?
4. Does the clinical supervision model affect preservice and inservice teachers differently?
5. Which planning and conferencing strategies are most effective?
6. Does clinical supervision lead teachers to be self-analytical?
7. Clinical supervision is supposed to be mutually beneficial. What are the "benefits" for the teacher and for the supervisor?
8. What skills and/or characteristics are needed by supervisors and teachers in order to use clinical supervision effectively?

9. Should the process change as it is used over time with in-service teachers (Should it be different for beginning teachers and experienced teachers?)?

These questions which are already formulated need to be examined; new questions need to be raised. The ambiguities which make the model unclear have resolutions. Various components of the model need to be scrutinized (Denham, 1977). Ideas for making the model applicable to schools as they exist should be explored. Suggested variations need to be tried. Whether clinical supervision does promote planned change needs to be determined. In addition, the possible effects of clinical supervision on two areas of educational concern should be considered.

Low teacher morale—known by a host of names including "teacher burn-out"—is currently a problem for educators (*Learning*, January 1979). The consequences are felt by a wide circle of individuals including faculties, staffs, administrators, parents, and pupils. The clinical supervision model appears to have the potential to alleviate low morale by making teaching a less isolated venture (through colleagueship with supervisor) and by partitioning seemingly overwhelming goals for instructional improvement into specific targets identified by the teacher. Clinical supervision should be tested as a method of improving morale and reviewed for effectiveness.

Career planning is another area in which clinical supervision appears to offer strengths worthy of future examination. The clinical supervision model appears to meet Lucio's (1969) criteria for a career development program: it determines the purposes and role performances of the persons affected. It may be that the specificity of the roles in clinical supervision would enable one to decide on, plan for, and have a career in supervision that is more than a job obtained through luck or politics.

If the clinical supervision model is widely used, resources needed for implementing the model will have to be determined. The analysis and strategy called for in clinical supervision may demand resources not currently delineated. Use of the strategy may mean expansion to specifically include a number of other sources, especially as replanning begins. For example, teacher centers which are appearing in many parts of the country may be resources in addition to the teacher and supervisor.

Other resources which may be appropriate as the clinical supervision cycle is used are task forces and teams of supervisors who engage in "collaborative, task-oriented efforts" (Harris, 1976, p. 334). Cogan (1973) refers to the cooperation of several individuals as "the staff concept in clinical supervision" and indicates that many different kinds of specialists and experts can be clinical supervisors.

What is the state of the art in clinical supervision? At this point there are more questions than answers, but the questions come from an identifiable design. Clinical supervision is clearly not a panacea, but it does have promise for both the theoretician and the practitioner.

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